DIVISION OF BEHAVIORAL HEALTH

SERVICE AUTHORIZATION TRAINING
FOR
MEDICAID BEHAVIORAL HEALTH PROVIDERS


What i'm about to tell you is gonna change your life forever. Are you really sure you want to know it?

SERVICE AUTHORIZATION TRAINING
Information To Learn (Objectives)

- Reasons for the system change
- How to document medical necessity based on current client information
- Examples of unacceptable documentation
- Example of a request that illustrates how to submit complete information
- How to convert service hours into billing units
- How to request the correct number of units your client needs
- How to use the Eligibility Verification System for Service Authorization information
- Claims and Service Authorization Resolution Options

SERVICE AUTHORIZATION TRAINING
Rationale

Reasons for system change:

- Providing the right service to the right person at the right time
- Adhere to new Medicaid Regulations 7 AAC 135
- Emerging federal landscape expects states to identify over and under utilization of services
- Service Authorization renamed from Prior Authorization to align with industry standards

SERVICE AUTHORIZATION TRAINING
Rationale

- Behavioral Health has responsibility to:

  A. Assure that those who need the most intensive services are the ones receiving them

  B. Prevent and identify overutilization of services when the services are not documented as medically necessary

  C. Assure that approved authorizations for services that exceed service limits are driven by and clearly linked to current:

  - client status reviews
  - treatment plans

WHEN CAN I GET STARTED?

Beginning July 1, 2012, all Service Authorizations will be sent by Xerox to DBH for medical necessity review.

Requests for dates of services that will exceed the limits beginning on or after July 1, 2012 can be submitted to Xerox starting June 1, 2012.

WHAT IF I HAVE A RETROACTIVE SERVICE AUTHORIZATION?

DBH will authorize retroactive requests that are within the timely filing period for the services for one year from dates of service.

Starting July 1, 2012, the new SA Request Form will be used for **all** requests.

a. For services before 12/1/11, use form effective 1/1/10

b. For services after 12/1/11, use form effective 12/1/11

c. For services after 7/1/12, use form effective 7/1/12

CLINICAL ASPECTS

Medical Necessity from #15 on CBHC SA Request Form & # 14 on MHPC SA Request Form

- Description of recipient's current maladaptive behavior
- Description of recipient's current functional status
- Reasons recipient is unable to maintain without the requested services

SERVICE AUTHORIZATION TRAINING
Definition of Current

- CURRENT is within the last 135 days
- CURRENT is within the last Treatment Plan Review
- CURRENT is **before the Treatment Plan EXPIRES AFTER 135 Days**

SERVICE AUTHORIZATION TRAINING
Use Specific Phrasing Such As:

USE THESE	NOT THESE
Crying when told no, Excessive Clinging	Cries Frequently, Angry Outbursts
Hypervigilance, Excessive Fear, Worry	Nervous, Afraid
Daredevil Behavior, Fire Setting In Last Week	Risky Behaviors, Hx Setting Fires
Runaway Less Than 24 hours (48 hrs, X # days)	Runs
Self-injurious Behavior, Hallucinations In Last Week (Specifically Describe)	Hurts Themselves, Sees Things
Drop in School Grades (A to D in Last 6 Weeks)	Not doing Well In School
School Time Outs 1x wk, Absent 3 Days in Last 5	Misses School
Suicidal / Homicidal Ideation With / Without Plan	Wants to Hurt Self
Detention @ Least 2x in Last 5 Days, Suspended & Note Reason, When Occurred	Made to Stay After School
Impulsive, Property Destruction, Threw the TV	Acts Without Thinking
Absent 5 Days from Work in Last Month	Misses Work
Arrest / Specific Illegal Activity in Last Month	Legal Troubles
Socially Withdrawn in Last Month	Stays to Themselves, Loner

SERVICE AUTHORIZATION TRAINING
Specific Description of Time

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

USE THESE	NOT THESE
In the Last Month	Has a History Of . . .
3x Week for Last 6 Months or Since the Last Treatment Plan Review	Recently
In the Last 48 Hrs.	Frequently, Often
In the Last Week	Seldom

SERVICE AUTHORIZATION TRAINING
Tips

- **Update Diagnosis:** with new numerical codes and changes to Treatment Plan
- **Note specific behaviors:** How do they interact with others, respond to directions, share feelings, peer interactions, any aggression –physical, verbal, what did they do? What intervention was required? Any self harm behaviors and was intervention required?
- **Individual Therapy**: are they sharing, resistant, issues discussed, current mental status
- **Family Therapy**: who participates, how do they interact, what are the issues?
- **Groups:** do they attend? Is the client discussing issues, giving feedback, how do they behave?

Tips (Continued)

- **Treatment Plan:** Is it consistent with the mental ability, developmental stage, generally accepted treatment, and practices for the particular symptoms , behavioral, and social dysfunctions exhibited by the client? Are the interventions effective and if not, what are your plans to address this? When is the expected discharge from your care? What is the discharge plan?

Tips (Continued)

- **School:** are they focused on task? Do they do the required work, What are their attendance and grades, what is their behavior in groups and when left alone to work independently?

- **Current Medications/ Testing ordered:** list meds, any changes and reasons, reason for meds, results of testing

- **Special Trips or Unforeseen Stressors:** describe events and client's response

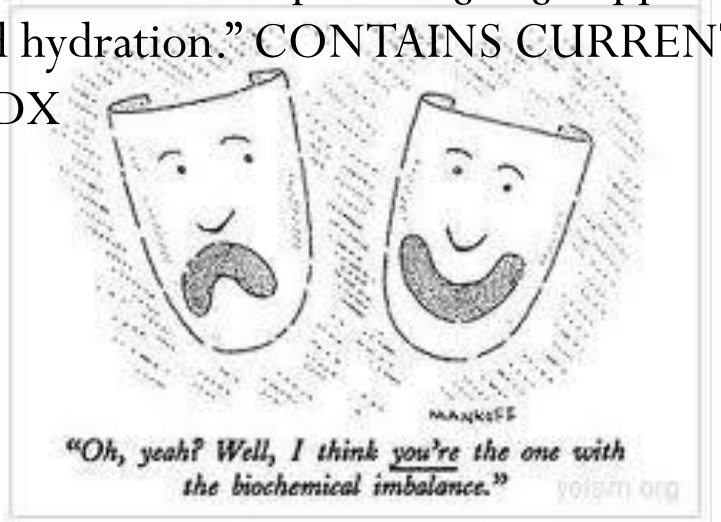
EXAMPLES OF INCOMPLETE DOCUMENTATION OF MEDICAL NECESSITY

- "John was brought by DJJ with a criminal history including thefts, burglary, sexual assault, and sexual abuse of a minor in the 4th degree. His delinquent behaviors include school suspension for fighting and substance use. He was prenatally exposed to alcohol and exhibits behaviors consistent with FASD." BEHAVIORS ARE NOT CURRENT; SPECIFIC NEED NOT NOTED
- "Sam has a significant history of consuming alcohol. Staff provide sight and sound when he consumes alcohol in his parked car outside of the residence. This supervision inhibits the client from risking harm to self or others." ILLEGAL TO DRINK IN CAR
- "Medicaid doesn't want clinical." LACK OF INFORMATION
- "Client is in crisis." LACK OF INFORMATION

State of Alaska Behavioral Health
May, 2012

ACCEPTABLE EXAMPLES

- "Fred is a 40 year old man diagnosed with Schizophrenia, paranoid type and Polysubstance Dependence, currently in remission supported by his level of care at the Group Home in Ptarmigan. He continues to struggle *daily* with memory impairment, disorganized thoughts, and has trouble remaining oriented to times, places, and tasks. He requires *daily* prompts and coaching by staff to perform *daily* hygiene tasks (showering, changing clothes) and to maintain a sanitary living space. His insight is extremely limited and he has trouble distinguishing between internal stimulation and reality and requires *daily* staff monitoring for safety, support, and direction to help him remain grounded and oriented. Fred also requires *ongoing* support to ensure adequate nutrition and hydration." CONTAINS CURRENT, SPECIFIC INFO RELATED TO DX



EXAMPLES OF INCOMPLETE DOCUMENTATION OF MEDICAL NECESSITY (Continued)

- "Mary is exhibiting symptoms of depression and a recent history of suicidal gestures. She needs inpatient treatment for continued stabilization and development of effective coping skills for life stressors." LACK OF CURRENT, SPECIFIC INFO

- "See AKAIMS." (AKAIMS was blank)

- "Client requires monitoring of food for nutritional status, history of colon disease. He exhibits a significant history of overeating and drinking. Staff provide supervision to maintain personal safety." LACK OF CURRENT, SPECIFIC INFO

ACCEPTABLE EXAMPLES (Continued)

- "Winnie is a 55 year old woman diagnosed with Chronic Schizophrenia, Paranoid type which was complicated by a compounding brain injury. She still suffers from delusional thinking, paranoia and auditory hallucinations on a *daily basis* and has limited insight into her illness' impact on her. Her psychosis continues to cause her to become verbally abusive towards others, including her peers in the group home and requires *constant* supervision by staff for redirection and intervention to curb this behavior. Winnie also continues to restrict her diet and attempts to water intoxicate. She requires *daily* staff monitoring to keep her healthy and prevent the onset of any medical emergencies. She further requires *daily* staff reminders to perform *daily* hygiene and to engage in healthy sleep and exercise routines. *Without this level of care, Winnie would not be able to* maintain the medication regimen as prescribed by the psychiatrist." CURRENT, SPECIFIC INFO RELATED TO DX, EXPLAINS REASONS NEEDS SERVICES

Outstanding Example and Possible Form From Duncan, Page 1

DSM-IV DIAGNOSITC CODE AND DESCRIPTION

AXIS l	**Clinical Disorders**
295.30	Schizophrenia, Paranoid type
296.90	Mood disorder, NO
AXIS II	**Personality Disorders/Mental Retardation**
317.0	Mild Mental Retardation
AXIS III	**General Medical Conditions**
	Fetal Alcohol Spectrum Disorder
	Diabetes, by medical record
	Hypertension by history
	Hyperthyroidism by history

Outstanding Example and Possible Form From Duncan, Page 2

AXIS IV **Psychosocial and Environmental Problems**

Problems with Primary Support Group: few friends, poor socio-sexual boundaries

Problems related to the Social Environment: vulnerable to negative influence

Educational Problems: limited education, no high school diploma

Occupational Problems: needs supports and job coaching to maintain employment, poor attendance, low motivation to work, related to symptoms of mental illness

Housing Problems: none

Economic Problems: below poverty line

Problems with Access to Health Care: Medicaid only

Legal/Criminal Problems: recent history of assault, involvement in Mental Health Court 7/08

Other Psychosocial Problems: difficulty relating to and interacting with others

AXIS V **Global Assessment of Functioning:** 30

Timeframe: (Date of Treatment Plan) 12/1/11 to 3/31/12

Outstanding Example and Possible Form From Duncan, Page 3

NARRATIVE:

Duncan is well known at the agency for his paranoid psychosis, aggression, and poor impulse control. Due to these symptoms, he has difficulty maintaining his daily ADLs and becomes aggressive with staff when prompted about proper hygiene or keeping up with his medical needs (i.e. insulin). Duncan has quick shifts in mood, from pleasant to aggressive or depressed when not provided with support or structure in the home. Since the last review, he broke the TV and a window when receiving limits on his diabetic diet. He becomes threatening when instructed his insulin dose, that he calculates, is incorrect. Due to these symptoms, he requires supervision and structure in the home and community setting in order to maintain safety to self and others.

Maladaptive behavior: becomes aggressive with staff; quick shifts in mood, from pleasant to aggressive or depressed

Functional status: difficulty maintaining his daily ADLs; his insulin dose, that he calculates, is incorrect

Unable to Maintain without services: Due to these symptoms, he requires supervision and structure in the home and community setting in order to maintain safety to self and others.

DUNCAN'S ENTIRE FORM

DSM-IV DIAGNOSITC CODE AND DESCRIPTION

AXIS l	**Clinical Disorders**
AXIS II	**Personality Disorders/Mental Retardation**
AXIS III	**General Medical Conditions**
AXIS IV	**Psychosocial and Environmental Problems**
AXIS V	**Global Assessment of Functioning**

Timeframe: (Date of Treatment Plan)

NARRATIVE

USING THIS FORM IS NOT REQUIRED;
COMPLETING IT CORRECTLY CAN EXPEDITE THE SERVICE AUTHORIZATION PROCESS

ADMINISTRATIVE PROCESS

IMPORTANT ADMINISTRATIVE INFORMATION

- Service Authorizations cannot cross over from one fiscal year to another
- Service Authorizations cannot be extended
- Additional dates require a new Service Authorization number
- Service Authorization updates can only contain a request for additional services and/or units
- High impact to billing/claims due to managing multiple SA numbers per fiscal year

NO DATE CHANGES (EXTENSIONS) BEGINNING

FISCAL YEAR 2013

WHICH STARTS JULY 1, 2012

NEW SERVICE AUTHORIZATION EACH TIME TREATMENT PLAN IS REVIEWED

WHAT DO I DO FIRST?

STEP 1 – COMPLETE A SERVICE AUTHORIZATION REQUEST FORM

- Fill out the SA Request form asking for the number of units prescribed in the treatment plan

- **SA Request form dates must be based on** the **Treatment Plan/CSR date**

- If you send a **New SA Request each month for less than Treatment Plan dates, then** claims for the service provided must match the authorized dates and the correct authorization number.

ADMINISTRATIVE PROCESS

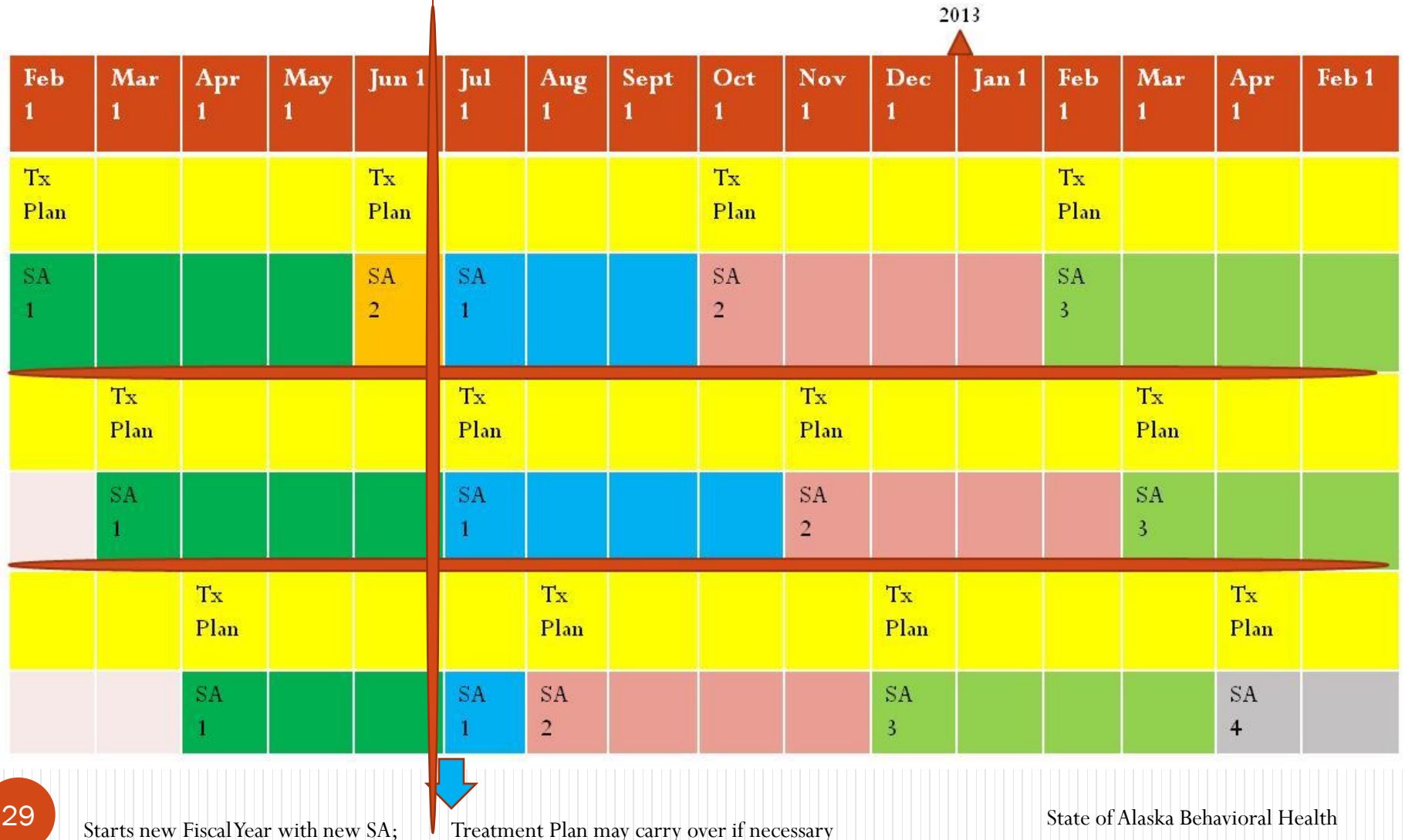
- Requesting for every 90-135 days will mean having fewer SA numbers to manage than if they are requested every 30.

- **Shorter requests** will receive a **new number each month and will never, ever change the dates.**

- **If more dates are needed, submit a new request.**

SERVICE AUTHORIZATION TRAINING RELATIONSHIP BETWEEN TREATMENT PLAN REVIEW DATE & SERVICE AUTHORIZATION

Requests are based on existing current treatment plan; authorization effective until next treatment plan review is due except at end of Fiscal Year.



Starts new Fiscal Year with new SA; Treatment Plan may carry over if necessary

Authorization Request Form for CBHC, page 1

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COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICE AUTHORIZATION (SA) REQUEST

Effective 07/01/2012

Page 1 of 3

Please complete pages 1 through 3 of this request. Only complete requests can be reviewed and processed.

1. Provider Name _____ 3. Recipient Name _____ 5. Request Date _____

2. Provider ID _____ 4. Recipient ID _____ 6. AK AIMS Client ID _____

Provider Information

7. Contact Name and Address

8. Phone No. _____

9. Fax No. _____

10. E-Mail Address _____

Recipient Information

11. Gender ☐Male ☐Female 12. Date of Birth _____

13. Type of Client:

☐ a. Adult w/ED ☐ b. Adult w/ SMI ☐ c. Child w/ED

☐ d. Child w/SED ☐ e. Adult w/SUD ☐ f. Child w/SUD

14. Enter Codes for DSM-IV-TR Axis IV

Axis I _____

Axis II _____

Axis III _____

☐ (a) Primary Support _____ ☐ (b) Social Environment _____

☐ (c) Occupation _____ ☐ (d) Housing _____

☐ (e) Economic _____ ☐ (f) Access to Health Care _____

☐ (g) Legal _____ ☐ (h) Other/Specify [Use 15(d)] _____

Axis V/GAF Score _____

15. Medical Necessity Description – Complete for ALL requests: attach separate paper if necessary. Fully describe the medical necessity of this request using a, b, c, and d, below, as they relate to the recipient.

(a) Maladaptive behavior within the last 135 days:

(b) Functional status within the last 135 days:

(c) Reason(s) recipient is unable to maintain without these services:

(d) Further description from Axis IV, above:

16. **Treatment plan/CSR Date:** _____
Enter the Treatment Plan/Client Status Review date that supports this Service Authorization Request

(a) ☐ **New Request** –SA From: _____ Thru: _____ (may not exceed 135 days correlated to treatment plan date)

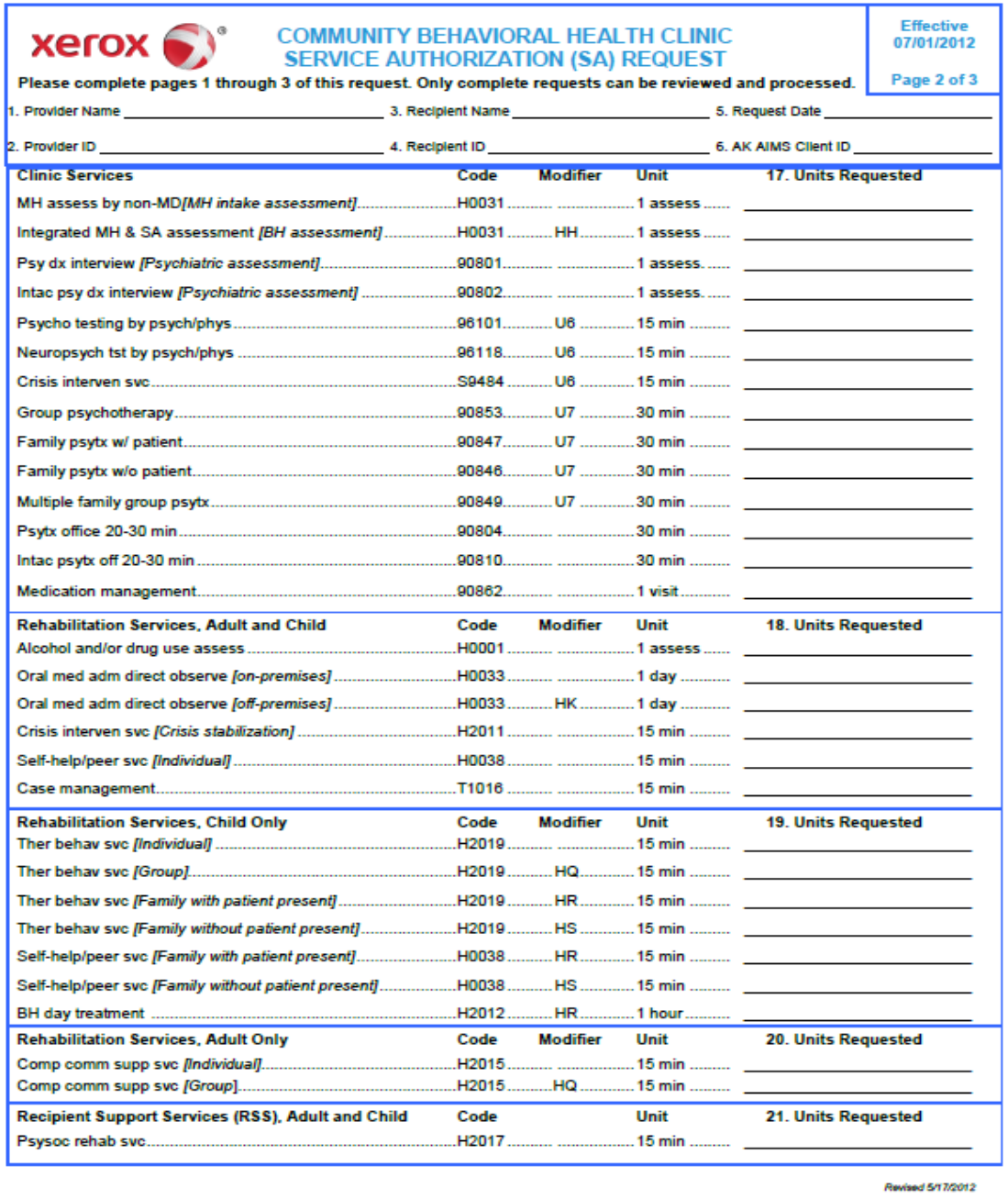
(b) ☐ **Update to existing SA** – to request additional services and/or units only; may not change date.SA No. _____
(Required for SA updates only)

Xerox Use Only: J/D _____ ☐New ☐Updated SA _____ Initials _____

Revised 5/17/2012

State of Alaska Behavioral Health
May, 2012

Authorization Request Form for CBHC, page 2



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COMMUNITY BEHAVIORAL HEALTH CLINIC
SERVICE AUTHORIZATION (SA) REQUEST

Effective 07/01/2012

Please complete pages 1 through 3 of this request. Only complete requests can be reviewed and processed.

1. Provider Name _____ 3. Recipient Name _____ 5. Request Date _____

2. Provider ID _____ 4. Recipient ID _____ 6. AK AIMS Client ID _____

Clinic Services	Code	Modifier	Unit	17. Units Requested
MH assess by non-MD *[MH intake assessment]*	H0031		1 assess	
Integrated MH & SA assessment *[BH assessment]*	H0031	HH	1 assess	
Psy dx interview *[Psychiatric assessment]*	90801		1 assess	
Intac psy dx interview *[Psychiatric assessment]*	90802		1 assess	
Psycho testing by psych/phys	96101	U6	15 min	
Neuropsych tst by psych/phys	96118	U6	15 min	
Crisis interven svc	S9484	U6	15 min	
Group psychotherapy	90853	U7	30 min	
Family psytx w/ patient	90847	U7	30 min	
Family psytx w/o patient	90846	U7	30 min	
Multiple family group psytx	90849	U7	30 min	
Psytx office 20-30 min	90804		30 min	
Intac psytx off 20-30 min	90810		30 min	
Medication management	90862		1 visit	

Rehabilitation Services, Adult and Child	Code	Modifier	Unit	18. Units Requested
Alcohol and/or drug use assess	H0001		1 assess	
Oral med adm direct observe *[on-premises]*	H0033		1 day	
Oral med adm direct observe *[off-premises]*	H0033	HK	1 day	
Crisis interven svc *[Crisis stabilization]*	H2011		15 min	
Self-help/peer svc *[Individual]*	H0038		15 min	
Case management	T1016		15 min	

Rehabilitation Services, Child Only	Code	Modifier	Unit	19. Units Requested
Ther behav svc *[Individual]*	H2019		15 min	
Ther behav svc *[Group]*	H2019	HQ	15 min	
Ther behav svc *[Family with patient present]*	H2019	HR	15 min	
Ther behav svc *[Family without patient present]*	H2019	HS	15 min	
Self-help/peer svc *[Family with patient present]*	H0038	HR	15 min	
Self-help/peer svc *[Family without patient present]*	H0038	HS	15 min	
BH day treatment	H2012	HR	1 hour	

Rehabilitation Services, Adult Only	Code	Modifier	Unit	20. Units Requested
Comp comm supp svc *[Individual]*	H2015		15 min	
Comp comm supp svc *[Group]*	H2015	HQ	15 min	

Recipient Support Services (RSS), Adult and Child	Code		Unit	21. Units Requested
Psysoc rehab svc	H2017		15 min	

Revised 5/17/2012

Authorization Request Form for CBHC, page 3

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COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICE AUTHORIZATION (SA) REQUEST

Effective 07/01/2012

Page 3 of 3

Please complete pages 1 through 3 of this request. Only complete requests can be reviewed and processed.

1. Provider Name _____ 3. Recipient Name _____ 5. Request Date _____

2. Provider ID _____ 4. Recipient ID _____ 6. AK AIMS Client ID _____

As the assigned directing clinician for the above named recipient, I hereby:

- Affirm the assessment of the recipient's symptomatology, current level of functionality is documented in the recipient's clinical record and the treatment plan services, units, and duration requested are medically necessary and consistent with the recipient's level of impairment.
- Affirm that, for a recipient who is a child, the clinical record documents the required participation and input of the child's treatment team.
- Acknowledge the services are subject to post-payment review of medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules; and
- Acknowledge that approval of this authorization request does not guarantee payment.

22. _____ _____ _____ _____

Directing Clinician Printed Name Credentials Signature Date

23. _____ _____

DBH Signature (based on information submitted by the provider agency) Date

Revised 5/17/2012

State of Alaska Behavioral Health
May, 2012

Authorization Request Form for CBHC Directions

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Community Behavioral Health Clinic Service Authorization (SA) Request Instructions

Effective 07/01/2012

Submission Requirements: This Service Authorization (SA) request must be completed to indicate the amount of services requested beyond the annual or daily service limits within the regulations (7 AAC 135.040) and must bear the signature of the directing clinician assigned to the recipient's case who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program rules. **Submit all Service Authorization requests directly to Xerox, the fiscal agent**, by fax at 866.653.1435 or by mail at Service Authorization, PO Box 240808, Anchorage, AK 995524-0808. Requests may be forwarded to the Division of Behavioral Health (DBH) for review.

Page 1:

Note: Fields 1-6. entered on page one will appear on all pages automatically.

1. **Provider Name:** Enter the name of the enrolled behavioral health services provider.
2. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the behavioral health clinic.
3. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
4. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
5. **Request Date:** Enter the date the authorization request is being submitted.
6. **AK AIMS Client ID:** Enter the Client ID number referenced within the Alaska Automated Information System (AK AIMS) for this recipient.
7. **Contact Name and Address:** Enter the name and address of the person Xerox or DBH staff should contact regarding the authorization request.
8. **Phone No.:** Enter the contact person's telephone number.
9. **Fax No.:** Enter the contact person's fax number, if applicable.
10. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
11. **Gender (recipient's):** Check appropriate box for male or female.
12. **Date of Birth:** Enter the recipient's date of birth.**Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
13. **Type of Client:** Indicate by marking all designations that are applicable to the client/recipient.
14. **Diagnostic & Statistical Manual of Mental Diseases – DSM-IV-TR: Axis I**—Behavioral health disorder. **Axis II**—Diagnosis. **Axis III**—Medical condition. **Axis IV**—Use check boxes for applicable contributing factors **Axis V**—Global assessment of functioning – GAF Score.
15. **Medical Necessity Description – Complete for ALL requests:** Fully describe the medical necessity for this request including a description of the recipient's (a) current maladaptive behavior, (b) functional status, (c) the reasons the recipient is unable to maintain without these services, and (d) use if additional space needed to describe factors from Axis IV. Attach separate paper if necessary.

16. **Treatment Plan/CSR Date:** _____

Enter the Treatment Plan/Client Status Review date that supports this Service Authorization Request

(a) **New Request**– Mark this box if the service authorization request is to initially exceed the annual service limits identified in regulation (7 AAC 135.040).

SA From Date: _____ Thru Date: _____

Enter the dates requested for the service authorization. Requests will be accepted only if the requests do not exceed 135 days from the treatment plan date.

(b) **Update to existing SA**—Mark this box when:

- Requesting an update to add additional units of service to an existing SA record.
- Adding services not already included in the existing SA.

Enter the number of the SA being updated, and then enter the cumulative total of units requested in section 17-21. The total should include any new units requested plus previous units, if applicable.

Page 2:

17-21. **Units Requested (Clinic Services):** Enter the cumulative total units of service that are being requested including the number of units previously requested if this is an update to an existing SA.

Page 3:

22. **Directing Clinician Signature:** The signature must be that of the directing clinician assigned to the recipient's case who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.
23. **DBH Signature:** The signature of the Division of Behavioral Health staff who reviewed the request.

Note: Medical necessity may be reviewed during post-payment review activities according to Medical Assistance program rules. DHSS may initiate recovery of funds paid for any services that are not medically necessary, not properly documented, or not in compliance with Medical Assistance program rules.

Revised 5/17/2012

Authorization Request Form for MHPC Page 1

xerox

MENTAL HEALTH PHYSICIAN CLINIC SERVICE AUTHORIZATION (SA) REQUEST

Effective 07/01/2012
Page 1 of 2

Please complete pages 1 through 3 of this request. Only complete requests can be reviewed and processed.

1. Provider Name _____ 3. Recipient Name _____ 5. Request Date _____

2. Provider ID _____ 4. Recipient ID _____

Provider Information

6. Contact Name and Address

7. Phone No. _____

8. Fax No. _____

9. E-Mail Address _____

Recipient Information

10. Gender ☐Male ☐Female 11. Date of Birth _____

12. Type of Client:

☐ (a) Adult w/ED ☐ (b) Adult w/ SMI ☐ (c) Child w/ED

☐ (d) Child w/SED ☐ (e) Adult w/SUD ☐ (f) Child w/SUD

13. Enter Codes for DSM-IV-TR

Axis I _____

Axis II _____

Axis III _____

Axis IV

☐ (a) Primary Support _____ ☐ (b) Social Environment _____

☐ (c) Occupation _____ ☐ (d) Housing _____

☐ (e) Economic _____ ☐ (f) Access to Health Care _____

☐ (g) Legal _____ ☐ (h) Other/Specify [Use 14(d)] _____

Axis V/GAF Score _____

14. Medical Necessity Description – Complete for ALL requests: attach separate paper if necessary. Fully describe the medical necessity of this request using a, b, c, and d below, as they relate to the recipient.

(a) Maladaptive behavior within the last 135 days:

(b) Functional status within the last 135 days:

(c) Reason(s) recipient is unable to maintain without these services:

(d) Further description from Axis IV, above:

15. **Treatment Plan Date:** _____
Enter the Treatment Plan date that supports this Service Authorization Request

(a) ☐ **New Request** –SA From: _____ Thru: _____ (may not exceed 135 days correlated to treatment plan date)

(b). ☐ **Update to existing SA** – to request additional services and/or units only; may not change date.SA No.: _____ (Required for SA updates only)

Xerox Use Only: _____ J/D _____ ☐ New ☐ Updated SA _____ Initials _____

Revised 5/17/2012

Authorization Request Form for MHPC Page 2

xerox

MENTAL HEALTH PHYSICIAN CLINIC SERVICE AUTHORIZATION (SA) REQUEST

Effective 07/01/2012

1. Provider Name _____ 3. Recipient Name _____ 5. Request Date _____

2. Provider ID _____ 4. Recipient ID _____

Clinic Services	Code	Modifier	Unit	16. Units Requested
MH assess by non-MD [MH intake assessment]	H0031		1 assess	
Integrated MH & SA assessment	H0031	HH	1 assess.	
Psy dx interview [Psychiatric assessment]	90801		1 assess.	
Intac psy dx interview [Psychiatric assessment]	90802		1 assess.	
Psytx office 20-30 min	90804		30 min	
Intac psytx off 20-30 min	90810		30 min	
Psycho testing by psych/phys	96101	U6	15 min	
Neuropsych tst by psych/phys	96118	U6	15 min	
Crisis interven svc	S9484	U6	15 min	
Group psychotherapy	90853	U7	30 min	
Family psytx w/patient	90847	U7	30 min	
Family psytx w/o patient	90846	U7	30 min	
Multiple-family group psytx	90849	U7	30 min	

As the mental health clinician for the above named recipient, I hereby

- Affirm the assessment of the recipient's symptomatology, current level of functionality is documented in the recipient's clinical record and the treatment plan services, units, and duration requested are medically necessary and consistent with the recipient's level of impairment
- Affirm that, for a recipient who is a child, the clinical record documents the required participation and input of the child's treatment team
- Acknowledge the services are subject to post-payment review of medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules
- Acknowledge that approval of this authorization request does not guarantee payment

17. _____ _____ _____ _____

Clinician Printed Name | Credentials | Signature | Date

18. _____ _____

DBH Signature (based upon information submitted by the providing agency) | Date

Revised 5/17/2012

Authorization Request Form for MHPC Directions

xerox

MENTAL HEALTH PHYSICIAN CLINIC SERVICE AUTHORIZATION (SA) REQUEST

Effective 07/01/2012

Submission Requirements: This service authorization (SA) request form must be completed to indicate the amount of services requested beyond the annual service limits within the regulations and must bear the signature of the supervising clinician assigned to the recipient's case who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program rules. **Submit all Service Authorization requests directly to Xerox, the fiscal agent,** by fax at 866.653.1435 or by mail at Prior Authorization, PO Box 240808, Anchorage, AK 995524-0808. Requests may be forwarded to the Division of Behavioral Health (DBH) for review.

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2. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the behavioral health clinic.
3. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
4. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
5. **Request Date:** Enter the date the authorization request is being submitted.
6. **Contact Name and Address:** Enter the name and address of the person Xerox or DBH staff should contact regarding the authorization request.
7. **Phone No.:** Enter the contact person's telephone number.
8. **Fax No.:** Enter the contact person's fax number, if applicable.
9. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
10. **Gender (recipient's):** Check appropriate box indicating male or female.
11. **Date of Birth:** Enter the recipient's date of birth. **Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
12. **Type of Client:** Indicate by marking all designations that are applicable to the client/recipient.
13. **Diagnostic & Statistical Manual of Mental Diseases – DSM-IV-TR: Axis I**—Behavioral health disorder. **Axis II**—Diagnosis. **Axis III**—Medical condition. **Axis IV**—Use check boxes for applicable contributing factors **Axis V**—Global assessment of functioning – GAF Score.
14. **Medical Necessity Description – Complete for ALL requests:** Fully describe the medical necessity for this request including a description of the recipient's current (a) maladaptive behavior, (b) functional status, (c) the reasons the recipient is unable to maintain without these services, and d) use if additional space needed to describe factors from Axis IV. Attach separate paper if necessary.
15. **Treatment Plan Date:** _____

    Enter the Treatment Plan date that supports this Service Authorization Request.

(a) **New Request –** Mark this box if the service authorization request is to initially exceed the annual service limits identified in regulation (7 AAC 135.040).

SA From Date: _____Thru Date: _____

Enter the dates requested for the service authorization. Requests will be accepted only if the requests do not exceed 135 days from the treatment plan date.

(b) **Update to existing SA –** Mark this box when:

- Requesting an update to add additional units of service to an existing SA record.
- Adding services not already included in the existing SA.

Enter the number of the SA being updated, and then enter the cumulative total of units requested in section 14. The total should include any new units requested plus previous units, if applicable.

Page 2:

16. **Units Requested (Clinic Services):** Enter the cumulative total units of service that are being requested including the number of units previously requested if this is an update to an existing SA.
17. **Supervising Clinician Signature:** The signature must be that of the supervising clinician assigned to the recipient's case who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.
18. **Division of Behavioral Health Signature:** The signature must be that of the authorized representative of the Division of Behavioral Health.

Revised 5/17/2012

SERVICE AUTHORIZATIONS WILL NEVER CROSS THE FISCAL YEAR

SERVICE LIMITS RESET EACH JULY 1

WHERE DO I SEND SERVICE AUTHORIZATION REQUESTS? STEP 2

- Send them to Xerox **as usual @ Fax to 866-653-1435**

- Xerox will screen the requests for current Medicaid eligibility and overlapping dates of service.
  - If the request has overlapping dates of service, it will be returned to provider (RTD'd)
  - If the recipient is ineligible for the dates requested, Xerox will deny

- Xerox will forward them to Behavioral Health (the way RSS is processed today)

WHERE DO I SEND SERVICE AUTHORIZATION REQUESTS? (Continued)
STEP 3

- Behavioral Health's review is focused on:
  - completeness of the SA Request Form
  - description of current maladaptive behavior
  - description of current functional status
  - description of recipient's need for requested services
  - documented relationship between mental health diagnosis and behaviors, functional status, and requested services

ADMINISTRATIVE PROCESS
HOW TO CALCULATE TOTAL UNITS NEEDED

1. If the service is anticipated 6 hours per day for 6 days per week = 36 hours/week

2. Multiply the weekly amount by # of weeks (135 days is almost 20 weeks) 36x20=720 hours

3. Subtract the allowable hours allowed per year(ex. 4 hrs)

   720 hrs-4 hrs=716 hrs

   Always remember to reduce requests by their allowable amounts.

4. Convert the remaining hours into units by multiplying x4 for 15 min units or 2 for 30 minute units

   716x4= 2864 units or 716 x2=1432 units

ADMINISTRATIVE PROCESS
PRESCRIPTION FOR SERVICES IN TREATMENT PLAN

		Frequency	Quantity	Duration	Total Hours – allowable hrs = Unit
H2019	(TBS)	hrs per wk	12	4mos	48 hrs 100 hrs none
90804	(IT)	hrs per wk	1	4 mos	16hrs-10=6hrs=12units
H2015	(CCS)	hrs per mo	100	4 mos	400hrs-240=160hr=640units

Total Order of Service:

		H2019 (TBS)	H2015 (CCS)
Hours ordered	16	48	400
Regulation approved	-10	100 hrs	-240
Total hours	6 hrs	none	160hrs
Units	Service	90804 (IT)	640 units@ 15 min each

DOUBLE CHECK YOUR CALCULATIONS

SUBMIT REQUESTS THAT TOTAL LESS THAN 24 HOURS A DAY

ADMINISTRATIVE PROCESS
STEPS FROM TREATMENT PLAN TO AUTHORIZATIONS

- Authorizations Start With the Clinician
- Assessment
- Treatment Plan
- Prescription for Treatment in Services and Hours
- Service Authorization Request Form with Number of Services and Hours

REASONS FOR POTENTIAL DENIAL

DENIED

- Documentation does not describe recipient's current maladaptive behavior

DENIED

- Documentation does not describe recipient's current functional status

DENIED

- Documentation does not describe the reason recipient is unable to maintain without the requested services

DENIED

- Lack of Relation to Mental Health Diagnosis (especially medical requests)

DENIED

- Lack of Information (**requests by DBH not fulfilled within 15 business days**)

MAKING THE DECISION STEP 4

- A Behavioral Health designee will make one of the following decisions:
  - Approve as requested
  - Deny the request
  - Alter the number of units requested which results in a partial denial
- They will make a determination and return them to Xerox
- Xerox will enter the decisions in MMIS and return them to providers **as usual**

SA REQUESTS RETURNED TO XEROX STEP 5

- Xerox returns the signed SA request to provider

  If the request is denied or partially denied, a denial letter is sent to the provider and recipient

  Recipient denial letter also contains a notice of fair hearing rights

WHAT IF MY CLIENT OR I DISAGREE WITH A BEHAVIORAL HEALTH DECISION?

- All determinations that deny or reduce the amount of requested services will be sent to both your clients and you.
- Your client may request a Fair Hearing and you may request an Appeal.
- Before you do that
- If we have made an error or you have additional information that was not included in the review, we want to hear from you. Please contact us first.

REASONS to Request an Appeal

- Denied or reduced claims (180 days)
- Denied or reduced service authorization (180 days)
- Disputed recovery of overpayment (60 days)

- Three Levels of Appeals:
  - First level appeals
  - Second level appeals
  - Commissioner level appeals

FIRST LEVEL APPEAL
7 AAC 105.270

A provider may request a first-level appeal of a decision that is denied or reduced if the provider submits a written request to Xerox no later than 180 days after the date of the decision.

They may be mailed to: Xerox
Attn: Appeals
P.O. Box 240808
Anchorage, AK 99524-0808

FIRST LEVEL APPEAL

Providers may also contact the fiscal agent's Provider Appeals staff at:

800.770.5650 Option 1, 5 (in-state, toll free)

or

907.644.6800 Option 8 (in Anchorage or outside Alaska)

SECOND LEVEL APPEAL
7 AAC 105.280

- If the decision is upheld providers have the right to file a second level appeal.
- A second level appeal must be filed by the provider within 60 days of the first level appeal decision.
- Providers must submit the same documentation listed above and include a copy of the first level appeal determination.
- Second level appeals should be submitted to:

  Dept. of Health and Social Services

  Division of Behavioral Health

  Attn: Claims Appeal Section

  3601 C Street, Suite 878

  Anchorage, AK 99503

COMMISSIONER LEVEL APPEAL

- ONLY used to challenge/appeal adverse timely filing denials/reductions

- Must be submitted in writing within 60 days of Second Level Appeal decision

Accessing Eligibility Verification System (EVS)

There is an Eligibility Verification System that providers may use to access service authorization information.

The link is: Recipient Eligibility - Packet at:

http://www.medicaidalaska.com/providers/Training/materials.shtml.

Press 5 for Service Limit information to know when to request authorizations

SERVICE AUTHORIZATION TRAINING

DBH Service Limit Category Codes for EVS

	Service Limit	Category Code	SL Description	SL Edit	Current UOM	Max Units	Proc Codes
13	DETOXIFICATION **Ended Use 12/01/2011**						
14	COUNSELING AND DAY TREATMENT **Ended Use 12/01/2011**						
15	Crisis Stabilization	641			Quarter Hour	88	H2011
16	Therapeutic Behavioral Health Services - Individual	642			Quarter Hour	400	H2019H0038
17	Therapeutic Behavioral Health Services - Group	643			Quarter Hour	560	H2019-HQ
18	Day Treatment for Children	772			1 hour	180	H2012
19	Neuropsychological Testing	775			Quarter Hour	48	96118 96118 - U6
20	Community Support Services - individual - Adult	644			Quarter Hour	960	H2015H0038
21	Community Support Services - Group - Adult	645			Quarter Hour	560	H2015-HQ
22	Therapeutic Behavioral Health Services - Family	646			Quarter Hour	720	H2019-HRH2019-HSH0038-HRH0038-HS
24	PHARMACOLOGIC MANAGEMENT **Ended Use 12/01/2011**						
25	Individual/Group/Family Psychotherapy Sessions	653			Half Hour	20	90844 9084990849-U7 9085390853-U7 9084790847-U7 90843 8415F 90804 90806 90810 90812 8473F9084690846-U7
26	Psychiatric Assessment	654			Assessment	4	8011F 9 0801 90802

DBH Service Limit Category Codes for EVS

Service Limit	Category Code	SL Description	SL Edit	Current UOM	Max Units	Proc Codes
27	Psychological Testing		655	Quarter Hour	24	96101 0601F 6015F CDBAQ
30	Crisis Intervention		659	Quarter Hour	88	1031F 3115F S9484S9484-U6
33	FUNCTIONAL ASSESSMENT **Ended Use 12/01/2011**		**663**			
34	INDIVIDUAL SKILLS DEVELOPMENT AGE <21 **Ended Use 12/01/2011**					
35	INDIVIDUAL SKILL 2 DEVELOPMENT AGE >= 21 **Ended Use 12/01/2011**					
36	GROUP SKILL DEVELOPMENT **Ended Use 12/01/2011**					
37	FAMILY SKILL DEVELOPMENT **Ended Use 12/01/2011**					
38	Case Management Services		668	Quarter Hour	720	8210F T1016

POINTS TO REMEMBER

Why are all the Procedure Codes like 90806, 90812 not on the Service Auth (SA) form?

SA requests are for billing codes with the smallest billing unit, so every procedure code/modifier combination is not present on the SA form but can be used for billing claims.

If the recipient's SA needs amending or updating and the directing clinician is not available, who else can sign it?

-The directing clinician's supervisor or whomever has been assigned to cover your patients because they are attesting that the completed form is current, accurate, and meets Medicaid requirements.

Can a provider deliver services after filing a SA while waiting for Behavioral Health to approve additional units?

-Yes, however the provider accepts that they may not receive reimbursement if the SA is denied.

Is Medical Necessity Description required for all SA requests?

-Yes

POINTS TO REMEMBER (Continued)

What specific detailed information needs to be in the medical necessity description of the SA form?

- At this time it is a description of the recipient's current maladaptive behavior, functional status, and the reason the recipient needs the services as supported by the Treatment Plan.

If a recipient has a SA on file and is being seen by one clinician and begins receiving services from another clinician in the same office, is a SA required for additional units?

- If additional units are needed to provide a service, they can be requested under the same, previously approved SA number.

If we used more units than have been approved, what do we do?

-File a retro request with documentation noting reasons more services were needed. The provider accepts that they may not receive reimbursement if SA is denied.

Tips for Success

- SA dates cannot overlap
- More units can be requested to update a Service Auth request but cannot change the dates
- One agency cannot operate under 2 Behavioral Health Treatment Plans at the same time

  (ex. SDS/BH & Waiver/BH ok)
- All services on 1 Service Auth for 1 time period

XEROX CONTACT

Provider Inquiry:
644-6800, press option 1
800-770-5650, press option 1, option 1, option 1

Enhanced Provider Support For Claims:

Chandra Lewis

644-6898

Chandra.Lewis@Xerox.com

Val Kenny 269-3797 Project Assistant

Valerie.Kenny@Alaska.gov

Lisa Brown, MSW 269-2051

Medicaid & Quality Supervisor

Lisa.Brown@Alaska.gov

Anne Gibson, RN, MS 269-8867 Reviewer

Anne.Gibson@Alaska.gov